



California Newborn Hearing Screening Program Outpatient Screening Reporting Form

Please use this form to report results. DO NOT attach waveforms, OAE printout, audiograms or reports. Please FAX or mail this form to the *Hearing Coordination Center [FAX # and Address]* within seven days of the child's outpatient hearing screening. If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center, as soon as possible, at [Phone Number].

Screening Provider: _____ Phone: _____ Fax: _____

Infant's Name: _____ Date of Screen: _____

AKA: _____ Date of Birth: _____ Gender: Female Male

Primary Care Provider (PCP): _____ Phone: _____

Birth Hospital: _____ WBN NICU County : _____

Insurance: ☐ Medi-Cal ☐ HMO ☐ Private Insurance ☐ Uninsured ☐ Unknown

Mother's Name (or Legal Guardian): _____

Address: _____ Phone Number: _____

Primary Language: ☐ English ☐ Spanish ☐ Other (specify) _____

Comments: _____

Screening Results: ☐ Initial Screen (1st) ☐ Re-screen (2nd)

	DPOAE		TEOAE		ABR(Screening)	
Right Ear	Pass	Refer	Pass	Refer	Pass	Refer
Left Ear	Pass	Refer	Pass	Refer	Pass	Refer

For infants who do not pass the outpatient screening:

Referral to CCS

Name of County: _____ Date: _____

Family's CCS application was forwarded to local CCS program ☐ Yes ☐ No

Referred for Diagnostic Evaluation

Name of Provider _____ Phone _____

Date of Appointment _____ Reason appointment not scheduled _____

Contact Information (Relative or Friend):

Name: _____ Phone: _____

Address: _____ Relationship: _____

This information is to be provided pursuant to Section 124119 of the California Health and Safety Code that requires you to report the results of audiological follow-up services provided through the California Newborn Hearing Screening Program.